



violet health®

Infusion Care

Patient Rights and Responsibilities

Welcome to our practice. This document outlines your rights as a patient and your responsibilities in your healthcare journey. Please read carefully and sign below.

Your Rights as a Patient

Access to Care

- Receive care regardless of race, sex (including gender identity and expression), color, religion, national origin, age, marital status, sexual orientation, disability, or veteran status
- Receive treatment in a clean, safe, and respectful environment
- Access emergency care when medically necessary
- Choose your healthcare providers and request second opinions
- Have visitors of your choice during permitted visiting hours, subject to medical appropriateness

Involvement in Your Care

- Be fully informed about your diagnosis, treatment options, potential risks, and prognosis in terms you can understand
- Participate actively in decisions about your healthcare and treatment plan
- Know the names and professional roles of those providing your care
- Receive proper assessment and management of pain
- Accept or refuse any treatment as permitted by law, and be informed of the potential consequences
- Be informed about any proposed research affecting your care and have the right to refuse participation
- Receive detailed instructions about your medication, potential side effects, and follow-up care

Privacy and Confidentiality

- Have your medical information kept confidential as required by law
- Access your medical records upon request
- Receive care with privacy and dignity
- Be free from all forms of abuse, harassment, or discrimination

Complaints and Grievances

You have the right to voice concerns about your care without fear of discrimination or retaliation. If you have a complaint:

1. First, attempt to resolve concerns directly with your healthcare provider or our office manager
2. If the issue remains unresolved, you may file a formal complaint by:
 - Speaking with our Clinical Director at 248-481-5328



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Infusion Care

- Submitting a written complaint to: 2256 Orchard Lake Rd. Bloomfield Township, MI 48320
- Emailing your concerns to hello@violetinfusions.com

You can also file complaints with external agencies, including:

- Michigan Department of Health: 517-335-8951
- Medicare (for Medicare beneficiaries): 1-800-MEDICARE (1-800-633-4227)
- The Joint Commission: 1-800-994-6610
- Michigan LARA Bureau of Professional Licensing: 517-241-0205

We will investigate all complaints and provide a written response within 15 business days.

Financial Information

- Receive clear information about the costs of your care before treatment
- Receive detailed explanations of your bills upon request
- Be informed about available payment options and financial assistance programs
- Know whether your providers accept your insurance, including Medicare assignment rates if applicable

Your Responsibilities as a Patient

Providing Information

- Provide accurate and complete information about your current health, medical history, medications (including over-the-counter), and any changes in your condition
- Inform us about any advance directives, living wills, or medical powers of attorney
- Provide accurate insurance and contact information, and promptly notify us of any changes

Participation in Care

- Follow your agreed-upon treatment plan
- Ask questions when you don't understand your care or what you're expected to do
- Keep scheduled appointments or notify us at least 24 hours in advance if you must cancel
- Arrive on time for appointments
- Ensure you have arranged for transportation and support after procedures when required

Conduct and Payment

- Treat all staff, other patients, and visitors with courtesy and respect
- Follow facility rules and regulations
- Respect the property and privacy of others
- Meet your financial obligations promptly
- Provide required insurance information and pay required co-pays at the time of service



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Emergency Situations

- Recognize what constitutes a medical emergency
- Call 911 or go to the nearest emergency room in case of a medical emergency
- Notify us of any urgent changes in your condition

Acknowledgment

I have read and understand my rights and responsibilities as a patient. I understand that this document will become part of my medical record.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

If signed by person other than patient:

Representative Name: _____

Relationship to Patient: _____

Representative Signature: _____